

MDR Tracking Number: M5-04-0964-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-02-03.

The IRO reviewed office visits, ultrasound therapy, myofascial release, group therapy procedures, physical medicine treatment, joint mobilization, therapeutic procedures and manual therapy rendered from 12-12-02 through 09-02-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-25-2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
1-2-03	99205	\$210.00 (1 unit)	\$0.00	N	\$137.00	96 MFG E/M GR (VI)(A)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$137.00
1-2-03	J1030	\$11.27 (1 unit)	\$0.00	G	DOP	96 PHARMACEUTICAL GR (I)(B)	Not global to any other service billed on date of service. Requestor

							submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$11.27
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
4-28-03	90900	\$300.00 (60 units)	\$0.00	A	\$2.00 per minute	Rule 134.600 (h)(4)	Denied for authorization. Services required pre-authorization. Requestor did not submit proof preauthorization was obtained. No reimbursement recommended.
5-8-03	99213	\$60.00 (1 unit)	\$0.00	D	\$48.00	Rule 133.307 (g)(3)(A-F)	D- Denied as a duplicate. Neither requestor nor respondent submitted original denial; therefore reviewer cannot determine reason for denial. No reimbursement recommended.
TOTAL		\$581.27	\$0.00				The requestor is entitled to reimbursement in the amount of \$148.27

This Decision is hereby issued this 3<sup>rd</sup> day of May 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

### ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at

the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-12-02 through 09-02-03 in this dispute.

This Order is hereby issued this 3<sup>rd</sup> day of May 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/dlh

February 24, 2004

#### NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0964-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The \_\_\_ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 55 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she began to experience right shoulder, right elbow and neck pain. An EMG dated 12/3/02 showed mild carpal tunnel syndrome on the right. In January of 2003 the patient underwent injection of the right wrist and repair of a right torn rotator cuff. In March of 2003 the patient underwent a MRI of the cervical spine that showed mild disc bulge at C4-5, broad based. June 2003 the patient underwent release of right carpal tunnel for right wrist carpal tunnel syndrome. A myelogram from September 2003 showed a minimal foraminal compromise. Treatment for this patient's condition has included therapy consisting of ultrasound therapy, electrical stimulation, hot/cold packs, paraffin, soft tissue mobilization, manipulations, and injections of the right wrist as well as epidural steroid injections of the lumbar spine by pain

management. The diagnoses for this patient have included right carpal tunnel syndrome, s/p right carpal tunnel release, torn rotator cuff, right shoulder, s/p surgical repair, and diffuse myofascial pain involving the trapezius muscles extensively, and in the right upper extremity muscles including the arm and proximal forearm muscles.

#### Requested Services

Office visits, ultrasound therapy, myofascial release, group therapy procedures, physical medicine treatment, joint mobilization, therapeutic procedures, and manual therapy from 12/12/02 through 9/2/03.

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

#### Rationale/Basis for Decision

The \_\_\_\_ chiropractor reviewer noted that this case concerns a 55 year-old female who sustained a work related injury to her right shoulder, right elbow and neck on \_\_\_\_\_. The \_\_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included right carpal tunnel syndrome, s/p right carpal tunnel release, torn rotator cuff, right shoulder, s/p surgical repair, and diffuse myofascial pain. The \_\_\_\_ chiropractor reviewer further noted that treatment for this patient's condition has included carpal tunnel release and physical therapy consisting of ultrasound therapy, electrical stimulation, hot/cold packs, paraffin, soft tissue, mobilization, manipulations, and injections of the right wrist as well as epidural steroid injections of the lumbar spine. The \_\_\_\_ chiropractor reviewer explained that the patient sustained many injuries from the work related incident on 5/6/02. The \_\_\_\_ chiropractor reviewer also explained that the amount of injuries this patient sustained can complicate this patient's healing process. However, the \_\_\_\_ chiropractor reviewer further explained that the patient responded well to the treatment rendered. Therefore, the \_\_\_\_ chiropractor consultant concluded that the office visits, ultrasound therapy, myofascial release, group therapy procedures, physical medicine treatment, joint mobilization, therapeutic procedures, and manual therapy from 12/12/02 through 9/2/03 were medically necessary to treat this patient's condition.

Sincerely,